

**STATE OF SOUTH DAKOTA
DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT**
Kneip Building
700 Governors Drive
Pierre, South Dakota, 57501-2291
(605) 773-3681

APPLICATION TO SELF-INSURE WORKERS COMPENSATION LIABILITIES

This application is for approval to self-insure workers compensation liabilities from September 1, 2009 to August 31, 2010. If the application is being made after September 1, 2009, the Certificate of Exemption will be valid only from the date of execution until August 31, 2010. A renewal application will be required for self-insurance during the 2010/2011 year.

This is an application for employers seeking to self-insure workers compensation in South Dakota. The attached schedules are to facilitate the submission of proof of solvency and financial ability to compensate under the provision of the Workers Compensation Law of South Dakota.

Answer all applicable questions fully. Specifically indicate N/A in any areas not applicable. If you are not completing this application electronically, please use black ink or type. If any questions are left unanswered, the application may be returned for completion, causing a delay in approval.

1. STATEMENT OF EMPLOYER IN SUPPORT OF APPLICATION

TO: State of South Dakota, Department of Labor
Division of Labor and Management
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3681

The undersigned, having elected to remain under the provisions of the Workers Compensation Law, hereby agrees to provide and pay all legal obligations under the Workers Compensation Law, including but not limited to compensation for the injuries to employees as required by Title 62 of the South Dakota Codified Laws or as may be awarded by the South Dakota Department of Labor. In making application for exemption from the insurance provisions of SDCL 62-5-1, the applicant hereby submits evidence of solvency and financial ability to pay compensation and other obligations contemplated.

(1.1) Name and address, including Zip + 4 of applicant.

(1.2) Federal Identification Number of applicant.

(1.3) Names and addresses, including Zip + 4, of all businesses to be self-insured in South Dakota (if necessary, additional businesses may be added on "Additional Notes" tab).

(1.4) Federal Identification Number of all businesses to be self-insured by South Dakota.

(1.5) Nature of Businesses.

(1.6) Are all businesses listed on application authorized to operate in South Dakota?

Yes

No

(1.7) Name and address, including Zip + 4, of person in South Dakota on whom legal service can be made.

(1.8) Name(s), address(es), and title of owner(s), partners or senior corporate officers.

2. COMPANY BACKGROUND

(2.1) Date Established.

(2.2) If incorporated, under laws of what state?

(2.3) Did firm succeed another firm?

Yes

☐

No

☐

(2.4) If yes, state whom and date of transition.

(2.5) Name(s) and addresse(es) of parent, subsidiary, and affiliate companies if any. Please specify affiliation.

(2.6) Is the parent, subsidiary or affiliated company guaranteeing the workers compensation of the applicant?

Yes

☐

No

☐

*If yes, attach notarized Assumption of Self-Insurance Obligations form.

*If yes, the financial data below should relate to all entities to be self-insured and the guarantor.

*If no, the financial data below should relate only to the entities to be self-insured.

(2.7) List all subsidiaries and affiliates to be self-insured and state the self-insurance retention limit on each. If necessary, additional subsidiaries and affiliates may be added on "Additional Notes" tab.

(2.8) List name and address, including Zip + 4, of all administrative branch offices and/or locations in South Dakota (if necessary, use Additional Notes Tab). If applicable, specify which are subsidiaries and which are divisions of the applicant.

3. FINANCIAL DATA

Please provide audited annual financial statements for the three (3) most recent years.

If audited annual financial statements are not available, please provide a balance sheet, income statement and statement of change in financial position for each year.

If the most recent audited annual financial statement does not report your financial position at a date within six (6) months of the beginning of the self-insurance year (September 1, 2009), provide an interim financial statement.

4. INSURANCE INFORMATION

(4.1) Has applicant been approved by the South Dakota Department of Labor to self-insure its workers compensation liabilities in the State of South Dakota prior to this application?

Yes No

(4.2) If yes, date applicant commenced self-insurance.

(4.3) Has applicant carried workers compensation insurance in South Dakota during any or all of the last three (3) years?

Yes No

(4.4) If yes, please attach the name of insurer and attach declaration pages or binder for each policy showing policy effective date, experience modifications, and South Dakota class codes and payroll.

(4.5) If no, has applicant been an approved self-insurer during the last three (3) years?

Yes No

(4.6) If no, how was workers compensation coverage provided?

(4.7) Expiration date of workers compensation policy now in effect.

(4.8) Is applicant authorized to self-insure its workers compensation liability in any other states?

Yes No

(4.9) If yes, please list the name of each state. If necessary, additional states may be added on "Additional Notes" tab.

(4.10) Has applicant ever been denied authority to self-insure its workers compensation or other liability in any state, or has such authority ever been revoked or suspended?

Yes No

(4.11) If yes, please list state(s) and date(s) (including South Dakota).

(4.12) Please fill out the Retention Limits Form below:

Year	<u>Per Occurrence</u>		<u>Aggregate</u>		Excess Insurer	Effective Date
	Retention	Excess* Limit	Retention	Coverage Limit		
2005						
2006						
2007						
2008						
2009						

*Dollar Limit or "Statutory"

(4.13) Please provide a copy of Certificate of Insurance for the most recent year to verify excess coverage levels and insurers.

(4.14) Does the applicant intend to maintain excess coverage through the upcoming self-insurance year (September 1, 2009, to August 31, 2010)?

Yes

No

5. ADMINISTRATION OF SELF-INSURANCE PROGRAM

(5.1) If workers compensation liabilities are currently self-insured, have you provided a scheme of compensation benefits whereby your South Dakota employees receive benefits that equal or exceed the benefits set forth in Title 62 (workers compensation) of the South Dakota Codified Laws?

Yes ☐ No ☐

(5.2) If so, please submit a copy of that plan.

(5.3) If you do not have a specific scheme of compensation, is it your intent to simply follow the statutory benefit requirements?

Yes ☐ No ☐

(5.4) How is/will the self-insured workers compensation claim experience be reflected in the applicant's financial statements?

(5.5) Is the claim reserve a separate line item in the financial statement? Yes ☐ No ☐

(5.6) Does the claim reserve include a provision for incurred but not reported (IBNR) claims?

Yes ☐ No ☐

(5.7) Is the claim reserve, if established, reflected on the balance sheet?

Yes ☐ No ☐

(5.8) If yes, where?

(5.9) If the response to any of the immediately preceding questions is negative (No), please provide a response from your auditor regarding FASB 112 compliance.

(5.10) How are case reserves established?

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(5.11) Key Claim Administrator

Name and Title
Name of Firm
Address
Telephone Number

(5.12) Indicate whether the following services are provided in-house or by an independent contractor.

<u>Services Provided</u>	<u>In-House</u>	<u>Contracted</u>
Accounting and Record Retention	<input type="text"/>	<input type="text"/>
Actuarial	<input type="text"/>	<input type="text"/>
Claims Administration	<input type="text"/>	<input type="text"/>
General Administration	<input type="text"/>	<input type="text"/>
Insurance	<input type="text"/>	<input type="text"/>
Legal	<input type="text"/>	<input type="text"/>
Loss Control/Safety	<input type="text"/>	<input type="text"/>
Rehabilitation	<input type="text"/>	<input type="text"/>
Risk Analysis/Management	<input type="text"/>	<input type="text"/>

(5.13) Individual responsible for paying your claims.

Name and Title
Name of Firm
Address
Telephone Number

(5.14) Does this person have authority to pay all claims?

Yes

☐

No

☐

(5.15) If no, please specify limits.

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6. EMPLOYEE AND PAYROLL DATA

(6.1) Total number of persons now employed in South Dakota.

(6.2) As of what date?

(6.3) Usual number of employees in South Dakota.

(6.4) Highest number of employees at one time in South Dakota during the last calendar year (2008).

(6.5) Total number of employees nationwide.

(6.6) As of what date?

(6.7) Actual payroll during each of the last three (3) calendar years. These figures must be from January 1, to December 31. Please provide a best estimate of the total wages to be paid in 2009 and 2010.

<u>Year</u>	<u>Payroll in South Dakota</u>	<u>Nationwide Payroll</u>
2006	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
2007	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
2008	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
Projected 2009	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
Projected 2010	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>

(6.8) Provide South Dakota payroll for the last (2) calendar years and projected for the current year and next year broken down by class code. Please use class code numbers only.

Total South Dakota

<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>	<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>
2007	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>	2008	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>	<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>
Proj 2009	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>	Proj 2010	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>
	<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>		<input style="width: 100%; height: 15px;" type="text"/>	<input style="width: 100%; height: 15px;" type="text"/>

7. LOSS DATA

Provide a history of all self-insured South Dakota losses & claim counts by accident year that have occurred up to 12/31/08, going back twelve valuation (accident) years. If applicant has not been self-insured for twelve years, provide the experience covered by private insurance if available. An accident year consists of all claims occurring during a 12 month period regardless of when the claim is reported.

Please provide the following through each valuation dated:

- Total number of closed counts on a **cumulative** basis
- Number of open claims on an **incremental** basis
- Total value of paid losses on a **cumulative** basis
- Total estimated case reserves on an **incremental** basis

For example, if accidents occurred in 1998 and \$500 had been paid on the claims by December 31 1998, enter \$500 in the 1998 row under the 12/31/98 valuation date column. If during 1999, an additional \$250 was paid for accidents occurring in 1998, and \$1,000 for accidents occurring during 1999, then the following entries would be made under the 12/31/99 valuation date column: \$750 in the row for the accident year 1998 (\$500 from the preceding column plus \$250 paid during 1999) and \$1,000 in the row for accident year 1998. The result would be

Accident Year	12/31/1997	12/31/1998	12/31/1999
1997			
1998	XXXXXX	500	750
1999	XXXXXX	XXXXXX	1,000

Note: this cumulating process **does not** apply to the number of open claims or the outstanding case reserves. Other year valuation dates and other 12 month accident periods can be used if desired instead of those indicated as long as the changes are applied uniformly and indicated clearly.

(7.1) MEDICAL ONLY PAID CLAIM COUNT (CLOSED) Valuation Date

Accident Year	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.2) LOST TIME PAID CLAIM COUNT (CLOSED)

Valuation Date

Accident

Year	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.3) TOTAL PAID CLAIM COUNT (CLOSED): (7.3) = (7.1) + (7.2)

Valuation Date

Accident

Year	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.4) MEDICAL ONLY OPEN CLAIM COUNT

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.5) LOST TIME OPEN CLAIM COUNT

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.6) TOTAL OPEN CLAIM COUNT: (7.6) = (7.4) + (7.5)

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.7) TOTAL REPORTED CLAIM COUNT: (7.7) = (7.3) + (7.6)

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.8) TOTAL PAID LOSSES

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.9) OUTSTANDING KNOWN CASE RESERVES

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.10) TOTAL REPORTED INCURRED LOSS: (7.10) = (7.8) + (7.9)

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.11) NATIONWIDE TOTAL INCURRED LOSS

Valuation Date

Accident

Year

	12/31/1997	12/31/1998	12/31/1999	12/31/2000	12/31/2001	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
1997												
1998	XXXXXX											
1999	XXXXXX	XXXXXX										
2000	XXXXXX	XXXXXX	XXXXXX									
2001	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2002	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2003	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2004	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2005	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2006	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2007	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2008	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

(7.12) Are incurred but not reported (IBNR) reserves calculated specifically for South Dakota?

Yes

☐

No

☐

(7.13) If yes, please provide an accident year history of IBNR by evaluation date.

(7.14) How much did the applicant pay in workers compensation self-insurance claims during the last calendar year or 12 month period consistent with how the data is reported on the preceding pages?

(7.15) MEDICAL EXPENSES

(7.16) DISABILITY EXPENSES

Temporary Total

Temporary Partial

Permanent Total

Permanent Partial

Rehabilitation

Death Benefits

TOTAL DISABILITY BENEFITS

(7.17) TOTAL DISABILITY + MEDICAL PAYMENTS

(7.18) How much loss reserve for self-insured workers compensation exposure in South Dakota is reflected in the applicant's financial statement?

CASE RESERVES:

IBNR RESERVES:

TOTAL:

(7.19) Has the applicant had any claims, which exceed or are expected to exceed the self-insurance retention under any excess insurance coverage?

Yes

☐

No

☐

(7.20) If yes, provide the amounts paid and incurred by accident year and valuation date for each such claim along with the applicable retention amount.

(7.21) If estimates of the South Dakota outstanding case reserves are not available, please provide a copy of the most recent loss run for the self-insured period.

(7.22) Please indicate Type and Dollar Amount of Security currently posted (please check all forms of security that apply)

<u>Type</u>	<u>Dollar Amount</u>	<u>Form of Security</u>
<input type="text"/>	<input type="text"/>	Bond
<input type="text"/>	<input type="text"/>	Cash
<input type="text"/>	<input type="text"/>	Certificate of Deposit
<input type="text"/>	<input type="text"/>	Triple A Rate Government Bonds
<input type="text"/>	<input type="text"/>	Irrevocable Letter of Credit
<input type="text"/>	<input type="text"/>	Irrevocable Trust Account
Total	<input type="text"/>	

(7.23) Person responsible for completing this application.

Name and Title _____
Company _____
Address _____
Telephone Number _____

(7.24) Person responsible for receiving correspondence, service, and other information from the South Dakota Department of Labor on the occasion that follow-up communications must be sent to a representative for the applicant.

Name and Title _____
Company _____
Address _____
Telephone Number _____

NOTE:

SDCL 62-5-21 provides:

Effective January 1, 1997, any self-insured employer shall provide medical services and health care to injured workers for compensable injuries and diseases under a managed care plan that meets the requirements established by rules promulgated by the department of labor pursuant to chapter 1-26.

ARSD 47:03:04:13.1 provides:

To demonstrate compliance with SDCL 62-5-21, each self-insured employer must submit documentation on a form provided by the department that the self-insured employer has adopted a self-insurance employer's managed care plan. This form must have been submitted with the self-insured employer's self-insurance application.

8. CONDITIONS OF EXEMPTION

In consideration of the approval of this application, the applicant hereby agrees as follows:

Applicant will provide surety for performance under the South Dakota Workers Compensation Law as follows:

1. A bond, on the form attached;
2. Cash;
3. Certificate of Deposit;
4. Triple A rate government bonds;
5. Irrevocable letter of Credit, on the form attached; or
6. Irrevocable Trust Account, on the form attached;

alone or in combination, in total amount equal to the greater of;

1. Two hundred and fifty thousand dollars (\$250,000.00);
2. Twice the amount of compensation claims paid by the applicant during the preceding calendar year; or
3. The amount designated by the applicant as a reserve for workers compensation claims.

Applicant agrees to furnish necessary information to support the correct amount of surety.

Applicant agrees to abide by all of the provisions of the Workers Compensation Law of the State of South Dakota.

Applicant agrees to fully discharge the obligations required by the provisions of the Workers Compensation Law.

The applicant further understands and agrees that:

The self-insurance privilege extended upon approval of this application applies only to the applicant and such businesses or subsidiaries which are included in this application.

Other businesses and subsidiaries may be included in the future under the applicant's self-insurance privilege upon written approval by the Department of Labor. After submitting such fees, financial information, and entering into any indemnification that the Department of Labor may require, approval may be granted.

The self-insurance privilege extended upon approval of this application will expire and terminate if the applicant is sold, merged, dissolved or otherwise changes its ownership interest to the extent that the financial conditions upon which approval was extended can no longer determine the applicant's financial ability to pay compensation benefits promptly in accordance with the law.

The South Dakota Department of Labor must be notified immediately of any changes in corporate structure, service company contracted with for handling claims or loss control, changes in in-house personnel administering the program, or any changes in South Dakota locations included in this authority.

Failure to comply with any laws, regulations, rules or requirements as set out by the South Dakota Codified Laws, this application, or the South Dakota a Department of Labor may result in revocation or suspension of the privilege to self-insure.

Any employer wishing to continue to self-insure its workers compensation liabilities under the provisions of Title 62 of the South Dakota Codified Law must annually furnish a statement of his financial condition, not later than the fifteenth (15th) day of July 2009. The certificate of exemption from the insurance requirements of the Workers Compensation Law will expire on the last day of August of each year, unless the certificate is sooner revoked or suspended by the South Dakota Department of Labor, and the permit must be renewed annually through filing of an application and financial statements. It is understood however, that the employer, upon giving the required notice, may waive this exemption from the insurance.

If any employer wishes to avail itself of the insurance exemption of the Workers Compensation Law, it must annually file with the South Dakota Department of Labor, proof as to its solvency and ability to pay the compensation, benefits, and fees provided by the law, and must submit financial statements as required. If the proof submitted is satisfactory and a sufficient showing is made, the applicant will be granted permission to operate as a self-insured employer, upon making the required deposit of securities with the Department of Labor. If, however, it is found from the statement and the proof submitted, that it does not have the financial capacity for the payment of such compensation, benefits, and fees, no certificate of exemption will be granted.

(8.1) STATE of _____

(8.2) COUNTY of _____

(8.3) I (we) hereby certify that the foregoing together with all statements or papers attached to and made a part hereof are true to the best of my (our) knowledge and belief, and (we) hereby bind myself (ourselves) and my (our) heirs, executors, and assigns to the complete fulfillment of all agreements here in contained.

Subscribed and sworn to before me this _____ day of _____, 2009.

My commission expires _____

9. ADDITIONAL NOTES

Please use this area for any additional notes you may have.